FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023952

Facility Name: Apostolic Christian Restmor

Address: 935 E. Jefferson (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: 309-266-7141 **Fax #** 309-266-7877

IDPA ID Number:

Date of Initial License for Current Owners: April 1978

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 c-3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael Kaiser **Telephone Number:** 309-266-7141

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) James Metzger

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	26	Sheltered Care (SC)	26	9,490	5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,452	22,314	3,253	36,019	8
9	SNF/PED					9
10	ICF	1,704	4,753		6,457	10
11	ICF/DD					11
12	SC	797	6,210		7,007	12
13	DD 16 OR LESS					13
14	TOTALS	12,953	33,277	3,253	49,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.86%

D. How many bed-hold days during this year were paid by Public Aid?
60 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on wheels, Pharmacy

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/78

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 4/1/78 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,253

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	331,015	27,545	126,692	485,252		485,252		485,252			1
2	Food Purchase		299,753		299,753	(9,198)	290,555	(14,687)	275,868			2
3	Housekeeping	96,864	3,467	38,494	138,825		138,825		138,825			3
4	Laundry	71,921	23,269	25,765	120,955		120,955		120,955			4
5	Heat and Other Utilities			122,001	122,001		122,001		122,001			5
6	Maintenance	101,510	23,076	138,420	263,006		263,006	2,348	265,354			6
7	Other (specify):* waste 17488, sec 1083			18,571	18,571		18,571		18,571			7
8	**TOTAL General Services**	601,310	377,110	469,943	1,448,363	(9,198)	1,439,165	(12,339)	1,426,826			8
	B. Health Care and Programs											
9	Medical Director			4,100	4,100		4,100		4,100			9
10	Nursing and Medical Records	2,278,822	132,315	194,241	2,605,378	(139,180)	2,466,198		2,466,198			10
10a	Therapy		1,645	142,228	143,873		143,873		143,873			10a
11	Activities	128,086	9,494		137,580		137,580		137,580			11
12	Social Services	134,551	697	380	135,628		135,628		135,628			12
13	Nurse Aide Training					11,531	11,531		11,531			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,541,459	144,151	340,949	3,026,559	(127,649)	2,898,910		2,898,910			16
	C. General Administration											
17	Administrative	156,261			156,261		156,261	(21,000)	135,261			17
18	Directors Fees											18
19	Professional Services			32,260	32,260		32,260	(2,350)	29,910			19
20	Dues, Fees, Subscriptions & Promotions			46,722	46,722	5,226	51,948	(34,824)	17,124			20
21	Clerical & General Office Expenses	240,728	40,811	83,286	364,825	(17,579)	347,246	(12,663)	334,583			21
22	Employee Benefits & Payroll Taxes			1,025,541	1,025,541	(10,491)	1,015,050	(9,198)	1,005,852			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,969	21,969	(3,542)	18,427	(5,397)	13,030			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,673	45,673		45,673		45,673			26
27	Other (specify):*											27
28	**TOTAL General Administration**	396,989	40,811	1,255,451	1,693,251	(26,386)	1,666,865	(85,432)	1,581,433			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,539,758	562,072	2,066,343	6,168,173	(163,233)	6,004,940	(97,771)	5,907,169			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Restmor #0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			278,995	278,995		278,995	(49,309)	229,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					25,066	25,066		25,066			35
36	Other (specify):*											36
37	**TOTAL Ownership**			278,995	278,995	25,066	304,061	(49,309)	254,752			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	248,157	1,253,367	55,252	1,556,776	138,167	1,694,943	(1,032,764)	662,179			39
40	Barber and Beauty Shops	28,663		3,131	31,794		31,794		31,794			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	276,820	1,253,367	124,083	1,654,270	138,167	1,792,437	(1,032,764)	759,673			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,816,578	1,815,439	2,469,421	8,101,438		8,101,438	(1,179,844)	6,921,594			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(1,032,764)	39		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,687)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(49,309)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(8,607)	20		17
18	Fines and Penalties	(1,724)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,257)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Sch 5A	(54,496)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,179,844)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,179,844)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Apostolic Christian Restmor

ID# 0023952

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Auto expenses	$ (5,448)	21	1
2	Employee meals	(9,198)	22	2
3	Financial consulting	(1,450)	21	3
4	Telephone income	(741)	21	4
5	Misc income	(240)	21	5
6	Misc expense	(4,617)	21	6
7	Medicare billing fees	(2,350)	19	7
8	Sunshine cart expense	(167)	21	8
9	Management Fees	(21,000)	17	9
10	Non allowable seminar	(2,259)	24	10
11	Deferred maintenance	2,348	6	11
12	Life Service Network for 2002	(6,236)	20	12
13	Non allowable travel	(3,138)	24	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,496)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Apostolic Christian Restmor # 0023952 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,687)	0	0	0	0	0	0	0	0	0	0	(14,687)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,348	0	0	0	0	0	0	0	0	0	0	2,348	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,339)	0	0	0	0	0	0	0	0	0	0	(12,339)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(21,000)	0	0	0	0	0	0	0	0	0	0	(21,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,350)	0	0	0	0	0	0	0	0	0	0	(2,350)	19
20	Fees, Subscriptions & Promotions	(34,824)	0	0	0	0	0	0	0	0	0	0	(34,824)	20
21	Clerical & General Office Expenses	(12,663)	0	0	0	0	0	0	0	0	0	0	(12,663)	21
22	Employee Benefits & Payroll Taxes	(9,198)	0	0	0	0	0	0	0	0	0	0	(9,198)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,397)	0	0	0	0	0	0	0	0	0	0	(5,397)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(85,432)	0	0	0	0	0	0	0	0	0	0	(85,432)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,771)	0	0	0	0	0	0	0	0	0	0	(97,771)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Restmor # 0023952 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(49,309)	0	0	0	0	0	0	0	0	0	0	(49,309)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(49,309)	0	0	0	0	0	0	0	0	0	0	(49,309)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,032,764)	0	0	0	0	0	0	0	0	0	0	(1,032,764)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,032,764)	0	0	0	0	0	0	0	0	0	0	(1,032,764)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,179,844)	0	0	0	0	0	0	0	0	0	0	(1,179,844)	45

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Henry Grimm, Director	0					
Greg Kaiser, Director	0					
Ken Baum, Director	0					
Ted Staker, Director	0					
Bruce Sauder, Director	0					
Ed Kaiser, Director	0					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	No Compensation to members of the board								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1				NONE			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Restmor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0023952

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1978	$ 125,000	1
2	Cong Living	1,139,030	1991-1999	217,586	2
3	TOTALS	1,356,830		$ 342,586	3

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1978	1961	$ 315,426	$ 56,496	25	$	$ (56,496)	$ 315,426	4
5				1962	59,373		25			59,373	5
6				1965	324,445		25			324,445	6
7				1971	2,813		20			2,813	7
8				1976	112,250		20			112,250	8
	Improvement Type**										
9				1978	15,000		20			15,000	9
10				1979	7,888		20			7,888	10
11				1980	50,819		16			50,819	11
12				1981	90,107		16			90,107	12
13				1982	96,603		18			96,603	13
14				1983	39,124		16			39,124	14
15				1984	243,503		16			243,503	15
16				1986	660,199	33,010	20	33,010		544,665	16
17				1986	18,532		18	1,030	1,030	16,995	17
18				1987	122,666	6,246	20	6,133	(113)	95,062	18
19				1987	27,395	1,333	20	1,370	37	21,235	19
20				1988	85,020	1,110	15	5,668	4,558	82,186	20
21				1989	46,665	1,436	15	3,111	1,675	41,999	21
22				1990	7,131	81	8--20	81		6,439	22
23				1991	38,812	2,962	10--15	2,962		35,046	23
24				1992	55,156	1,478	5--10	1,478		54,417	24
25				1993	46,959	4,696	10	4,696		38,790	25
26				1994	3,462	346	10	346		2,479	26
27				1995	64,958	4,163	10--15	4,163		28,543	27
28	Locking System			1996	12,447	830	15	830		4,979	28
29	Roof Repairs			1996	2,500		5			2,500	29
30	Water Heater			1996	7,066	707	10	707		4,240	30
31	Sink			1996	3,148	210	15	210		1,259	31
32	Carpet			1996	1,824	182	10	182		1,079	32
33	Quick Channels			1996	585	58	10	58		345	33
34	Oxygen Control Manager			1996	5,301	442	12	442		2,577	34
35	Room Closets			1996	44,000	2,200	20	2,200		12,467	35
36	Ventilator Remodeling										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ventilator Remodeling	1996	$ 34,281	$ 2,285	15	$ 2,285	$	$ 12,950	37
38	Carpeting	1996	20,762	2,076	10	2,076		11,592	38
39	Sewer Repair	1996	5,534	369	15	369		1,998	39
40	Roofing Repair	1996	2,950	344	5	344		2,950	40
41	Wallpaper Drapes	1996	5,409	361	15	361		1,954	41
42	Dining Room Door	1997	1,658	111	15	111		535	42
43	Electric Installed for A/C	1997	2,300	115	20	115		537	43
44	Floor Covering Therapy	1997	656	66	10	66		290	44
45	Fire Alarm System	1998	15,800	1,317	12	1,317		5,267	45
46	Conference Room carpet	1998	1,112	111	10	111		408	46
47	Shower Repairs	1998	1,524	102	15	102		364	47
48	A/C Compressor	1998	6,485	811	8	811		2,905	48
49	Pharmacy Building Improvements	1998	2,503	167	15	167		515	49
50	Broom Closet	1998	700	47	15	47		144	50
51	Ceiling Tile	1999	1,600	160	10	160		480	51
52	Pharmacy Building Improvements	1999	8,585	572	15	572		1,669	52
53	Door Alarm	1999	6,075	868	7	868		2,531	53
54	Bulletin Boards	1999	5,669	567	10	567		1,606	54
55	Wallcovering Room 117	1999	889	89	10	89		245	55
56	Nursing Office	1999	4,401	440	10	440		1,137	56
57	Computer Cables	1999	11,475	1,639	7	1,639		3,961	57
58	Blinds	1999	605	61	10	61		142	58
59	Break Room Carpet	1999	1,515	216	7	216		487	59
60	Marketing Office Electric	1999	2,768	185	15	185		493	60
61	Thin Trees	1999	1,765	353	5	353		1,059	61
62	Mulch	1999	1,300	433	3	433		1,191	62
63	Exhange Oil Tanks	1999	15,833	1,056	15	1,056		2,727	63
64	Roof Repair	2000	4,365	2,182	2	2,182		4,365	64
65	Dining Room Floor	2000	2,788	697	4	697		1,115	65
66	Vestibule Alarm	2000	4,618	1,555	4	1,555		2,132	66
67	Bathroom Floor Covering	2000	1,229	307	4	307		461	67
68	Air Duct for Telephone	2000	3,160	790	4	790		1,185	68
69	Med Room A/C	2000	5,483	1,097	5	1,097		2,102	69
70	TOTAL (lines 4 thru 69)		$ 2,796,974	$ 139,535		$ 90,226	$ (49,309)	$ 2,426,150	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,796,974	$ 139,535		$ 90,226	$ (49,309)	$ 2,426,150	1
2	Dining Room Compressor	2000	4,348	870	5	870		1,667	2
3	Trees	2001	3,500	29	20	29		29	3
4	New Sidewalk	2001	2,920	49	10	49		49	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,807,742	$ 140,483		$ 91,174	$ (49,309)	$ 2,427,895	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,305,741	$ 116,929	$ 116,929	$	3--20	$ 890,822	71
72	Current Year Purchases	96,626	10,983	10,983		3--12	10,983	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,402,367	$ 127,912	$ 127,912	$		$ 901,805	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Bus, 1996 dodge van	1990, 1996	$ 60,654	$	$	$		$ 60,654	76
77	Pharmacy Transportation	1992 van	1999	7,459	1,865	1,865			5,594	77
78	Staff & Administration	1998 century wagon	1998	44,940	7,490	7,490			29,960	78
79	Facility Management	Machinery & Equip		14,719	1,246	1,246			3,737	79
80	TOTALS			$ 127,772	$ 10,601	$ 10,601	$		$ 99,945	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,680,467	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 278,996	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,687	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (49,309)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,429,645	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 25,066 Description: Vents $9000, plants $1120, copier $12650, voice recorders $736, storage $1560
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		4,640		4,640
5	In-House Trainer Wages	(c)		6,091		6,091
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			800		800
9	TOTALS		$	$ 11,531	$	$ 11,531
10	SUM OF line 9, col. 1 and 2	(e)	$ 11,531			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 15,024	$		$ 15,024	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			14,603			14,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			25,083			25,083	4
5	Physician Care	39-3	visits			225			225	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	261,154		25,750	1,283,766		1,570,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39		82,750		0	35,899		118,649	12
13	Other (specify): Lab	39				5,399			5,399	13
14	TOTAL			$ 343,904		$ 86,084	$ 1,319,665		$ 1,749,653	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Restmor **#** 0023952 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,379	$	1
2	Cash-Patient Deposits	7,278		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	997,670		3
4	Supply Inventory (priced at)	210,240		4
5	Short-Term Investments	2,318,746		5
6	Prepaid Insurance	20,479		6
7	Other Prepaid Expenses	60,351		7
8	Accounts Receivable (owners or related parties)	39,141		8
9	Other(specify):	14,937		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,670,221	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	347,586		13
14	Buildings, at Historical Cost	2,182,754		14
15	Leasehold Improvements, at Historical Cost	985,349		15
16	Equipment, at Historical Cost	1,530,139		16
17	Accumulated Depreciation (book methods)	(3,865,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,180,849		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	182,047		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,543,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,213,357	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 185,723	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,278		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,782		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,002		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Pension	191,763		36
37	Accrued PTO	272,755		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 794,303	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 794,303	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,419,054	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,213,357	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,442,657	1
2	Restatements (describe):		2
3	**PPA to account for facility ownership of Health Ins pool**	107,366	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,550,023	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	869,032	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 869,032	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,419,055	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,604,083	1
2	Discounts and Allowances for all Levels	(130,096)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,473,987	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,155,728	5
6	Therapy	257,114	6
7	Oxygen	3,526	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,416,368	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	41,328	13
14	Non-Patient Meals	30,561	14
15	Telephone, Television and Radio	741	15
16	Rental of Facility Space		16
17	Sale of Drugs	536,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,908	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 654,076	23
	D. Non-Operating Revenue		
24	Contributions	1,149,408	24
25	Interest and Other Investment Income***	142,361	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,291,769	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Supplies	106,719	28
28a	Statement 1	27,551	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 134,270	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,970,470	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,446,388	31
32	Health Care	3,024,579	32
33	General Administration	1,697,206	33
	B. Capital Expense		
34	Ownership	278,995	34
	C. Ancillary Expense		
35	Special Cost Centers	1,588,570	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,101,438	40
41	**Income before Income Taxes (line 30 minus line 40)****	869,032	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 869,032	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,805	2,080	$ 64,985	$ 31.24	1
2	Assistant Director of Nursing	1,928	2,280	49,861	21.87	2
3	Registered Nurses	23,779	25,148	525,492	20.90	3
4	Licensed Practical Nurses	18,435	20,487	324,667	15.85	4
5	Nurse Aides & Orderlies	95,831	102,744	1,107,792	10.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,552	4,830	59,299	12.28	8
9	Activity Director	2,425	2,651	31,084	11.73	9
10	Activity Assistants	9,954	10,509	97,002	9.23	10
11	Social Service Workers	4,827	5,244	85,468	16.30	11
12	Dietician	80	251	4,217	16.80	12
13	Food Service Supervisor	1,944	2,080	30,537	14.68	13
14	Head Cook	1,214	1,299	16,577	12.76	14
15	Cook Helpers/Assistants	32,826	34,944	279,684	8.00	15
16	Dishwashers					16
17	Maintenance Workers	7,778	8,592	101,510	11.81	17
18	Housekeepers	12,067	13,236	96,864	7.32	18
19	Laundry	7,789	8,551	71,921	8.41	19
20	Administrator	1,730	2,098	95,265	45.41	20
21	Assistant Administrator	1,840	2,080	60,996	29.33	21
22	Other Administrative	2,005	2,072	39,313	18.97	22
23	Office Manager	1,960	2,080	61,606	29.62	23
24	Clerical	8,517	9,222	125,137	13.57	24
25	Vocational Instruction					25
26	Academic Instruction	1,742	2,080	51,087	24.56	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,627	3,945	49,083	12.44	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Medical Records a	8,907	9,480	95,639	10.09	32
33	Other(specify) Pharm, Beauty, V	17,760	18,996	291,492	15.34	33
34	TOTAL (lines 1 - 33)	275,322	296,979	$ 3,816,578 *	$ 12.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	121	$ 3,029	1-3	35
36	Medical Director		4,100	9-3	36
37	Medical Records Consultant	12	750	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	133	$ 7,879		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,267	$ 45,562	10-3	50
51	Licensed Practical Nurses	390	12,128	10-3	51
52	Nurse Aides	7,263	118,441	10-3	52
53	TOTAL (lines 50 - 52)	8,920	$ 176,131		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Metzger	Adm.		$ 95,265
John Kelley	Asst Adm.		60,996
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,261

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson LLP	Accounting	$ 7,600
Duane Morris & Heckscher	Legal	4,877
Frost Ruttenberg & Rothblatt	Medicare/Medicaid	756
Hel, Royster, Voelker & Allen	Legal	165
Judge, William J	Legal	500
Thomas Davies	Legal	90
Principal Financial Group	Pension Adm	7,081
Accu Med Services	Quality Incicators	900
Achieve Healthcare co	Software Training	3,412
Life Services Network	Wellspring	2,859
Personnel Planners	Worker's Comp	1,670
Specialized Ins Assistance	D-Merc	2,350
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,014
Unemployment Compensation Insurance	3,042
FICA Taxes	284,596
Employee Health Insurance	395,066
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	6,944
Life Insurance	9,421
Pension Expense	194,118
Uniform Rental	2,655
Tuition Reimbursement	1,997
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,005,853

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,722
Health Care Worker Background Check	456
(Indicate # of checks performed 38)	
Dues Fees Per Schedule	3,292
AAHSA--2001	1,654
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,124

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,404
Seminar Expense	6,626
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,030

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repair walk in coolers	1/2000	$ 827	3	$	$	$ 276	$ 276	$ 275	$	$	$	$
2	Repair dining room furna	3/2000	3,401	3			945	1,134	1,134	188			
3	Repair shower room plum	6/2000	707	3			138	236	236	97			
4	Repair hot water booster	9/2000	534	3			59	178	178	119			
5	Repair refridgerator	10/2000	776	3			65	259	259	193			
6	Repair dining room furna	12/2000	796	3			22	265	265	244			
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,041		$	$	$ 1,505	$ 2,348	$ 2,347	$ 841	$	$	$

Facility Name & ID Number Apostolic Christian Restmor # 0023952 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. AAHSA $1654

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 144

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-12

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 49,345 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 9,198 Has any meal income been offset against related costs? Yes Indicate the amount. $ 9,989

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? partial
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Review
Firm Name: Clifton Gunderson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Statement 1
Detail for Schedule XVII line 28a

Consulting	1450
Social Activities Income	950
Personal Supplies sold to patients	2798
Sunshine Cart Expenses	1113
Misc Income	240
Management Fee for Congregate Living	21000
Total	27551

Statement 2

Schedule XIV
Reconciliation to Line 39

Total From Sch XIV	1749653
Less Amount on line 10a	-54710
Less Outside Pharmacy	-1032764
Amount on Line 39	662179